TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Trenton D. Weeks, D.C.

Respondent Name
Chubb Indemnity Insurance Company

MFDR Tracking Number
M4-17-1653-01

Carrier's Austin Representative
Box Number 17

MFDR Date Received
February 1, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "03/02/2016- Billed examination was sent to carrier via electronically. (28 days)
05/05/2016- Request for Bill Status was sent to carrier via fax. (92 days)
- No response from Carrier.
08/06/2016- Request for reconsideration sent to carrier via fax. (6months, 3 days 08/28/2016 Carrier EOR of denied payment indicating the time limit for filing has expired."

Amount in Dispute: $500.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: Submitted documentation does not include a position statement from the respondent. Accordingly, this decision is based on the information available at the time of review.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 4, 2016	Examination to Determine Maximum Medical Improvement & Impairment Rating	$500.00	$500.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.20 sets out the procedures for submitting a medical bill.
3. 28 Texas Administrative Code §134.204 sets out the fee guidelines for division-specific services from March 1, 2008 until September 1, 2016.

4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 29 – Time Limit for Filing Claim/Bill has Expired.

Issues

1. Did Chubb Indemnity Insurance Company (Chubb) respond to the medical fee dispute?
2. Is Chubb's denial of the disputed services supported?
3. Is Dr. Weeks entitled to reimbursement for the services in question? If so, what is the reimbursement amount?

Findings

1. The Austin carrier representative for Chubb is Downs-Stanford, P.C. Downs-Stanford, P.C. acknowledged receipt of the copy of this medical fee dispute on February 9, 2017.

   28 Texas Administrative Code §133.307 states, in relevant part:

   > (d) Responses. Responses to a request for MFDR shall be legible and submitted to the division and to the requestor in the form and manner prescribed by the division.
   > (1) Timeliness. The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile **within 14 calendar days after the date the respondent received the copy of the requestor's dispute** [emphasis added]. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information.

   Review of the documentation finds that no response has been received on behalf of Chubb from Downs-Stanford, P.C. to date. The division concludes that Chubb failed to respond within the timeframe required by §133.307(d)(1). For that reason the division will base its decision on the information available.

2. Dr. Weeks is seeking reimbursement for an examination performed on February 4, 2016, to determine maximum medical improvement and impairment rating, as referred by the treating doctor. Dr. Weeks billed for these services with procedure code 99456-WP.

   Chubb denied the disputed services with claim adjustment reason code 29 – "The Time Limit for Filing Claim/Bill has Expired." 28 Texas Administrative Code §133.20(b) requires that "Except as provided in Labor Code §408.0272(b), (c) or (d), a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided …"

   Review of the submitted information finds a fax confirmation page supporting that a medical bill for the services in question were submitted to the insurance carrier on May 5, 2016. This date is less than 95 days after the date of service. The insurance carrier's denial reason is not supported. The services will be reviewed in accordance with applicable rules and fee guidelines.

3. Per 28 Texas Administrative Code §134.204(j)(3), "The following applies for billing and reimbursement of an MMI evaluation… (C) An examining doctor, other than the treating doctor, shall bill using CPT Code 99456. Reimbursement shall be $350." The submitted documentation supports that Dr. Weeks performed an evaluation of Maximum Medical Improvement. Therefore, the reimbursement for this examination is $350.00.

   28 Texas Administrative Code §134.204(j)(4)(D) states that:

   > (i) Non-musculoskeletal body areas are defined as follows:
   > (I) body systems;
   > (II) body structures (including skin); and,
   > (III) mental and behavioral disorders.
   > (ii) For a complete list of body system and body structure non-musculoskeletal body areas, refer to the appropriate AMA Guides…
   > (v) The MAR for the assignment of an IR in a non-musculoskeletal body area shall be $150.

Review of the submitted documentation finds that Weeks performed an impairment rating evaluation of the right chest. Therefore, the reimbursement for this examination is $150.00.

The total reimbursement for the disputed services is $500.00. This amount is recommended.

Conclusion

The outcome of this medical fee dispute relied upon the evidence presented by the requestor and the respondent at the time of adjudication. Though all the evidence may not have been discussed, it was considered. For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $500.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Sec. 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $500.00, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

	Laurie Garnes	April 14, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.